

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115596	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Tucker Operating Company LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2165 Idlewood Road Tucker, GA 30084	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility policy titled, Elopements and Wandering Residents, the facility failed to report elopement within two hours to law enforcement and the State Agency for one of four sampled residents (R) (R1). Findings include: Review of the undated facility policy titled Elopements and Wandering Residents documented under Policy: This facility ensures that Residents who exhibit and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with the Resident Centered Care Plan addressing the unique factors contributing to wandering or elopement risk. Under Policy Explanation and Compliance Guidelines: 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 4. a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. d. Adequate supervision will be provided to help prevent accidents or elopements. 5. c. If the resident is not located in the building or on the grounds, Administrator or designee will notify the police department and serve as the designated liaison between facility and the police department. g. Appropriate reporting requirements to the State Survey agency should be conducted. Review of R1's face sheet showed R1 was admitted with diagnoses of but not limited to cerebral infarction, end stage renal disease, cognitive communication deficit, unspecified dementia, and psychotic mood disturbance. Review of R1's admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated R1 had severe cognitive impairment. Review of R1's Comprehensive Care Plan (CCP) Initiated on 10/1/2025 documented R1 was at risk for wandering looking for his home. R1 was disoriented to place, had impaired safety awareness and wandered aimlessly. Care plan directed staff to distract R1 from wandering by offering pleasant diversions, structured activities, food, conversation, television and books. During an interview on 10/8/2025 at 11:59 am with the Administrator revealed on 10/1/2025 at approximately 8:20 pm, staff reported R1 was missing. She told staff to look everywhere inside and outside the building. The Administrator explained that facility staff were under the impression R1 was unable to walk and concentrated on searching the inside of the facility. The Administrator explained at approximately 10:15 pm that the facility owner located R1. The Administrator stated she attempted to call law enforcement and was on hold for 40 minutes and eventually hung up without making a police report. During an interview on 10/9/2025 at 12:29 pm, the Administrator revealed she did not notify the State Agency since R1 was not harmed.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 115596	If continuation sheet Page 1 of 3

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident representative and staff interviews, record review, and review of the facility policies titled, Incident and Accidents and Elopements and Wandering Residents, the facility failed to prevent the elopement of one of four sampled residents (R) (R1). The deficient practice had the potential to place R1 and other cognitively impaired residents at risk of compromised health and safety. Findings include: Review of the facility policy titled Incidents and Accidents revised 9/23/2025 documented under Policy: It is the policy of the facility for staff to report, investigate and review any accidents or incidents that occur, on facility property and may involve or allegedly involve a Resident. Under Definitions: An incident is defined as an occurrence or situation that is not consistent with the routine care of a Resident or with the operation of the organization. Under Compliance Guidelines: .5. The following incidents/accidents require an incident/accident report but are not limited to: Alleged abuse, Choking, Combative behavior, Drug diversion, Elopement, Entrapment and Falls. Review of the undated facility policy titled Elopements and Wandering Residents documented under Policy: This facility ensures that Residents who exhibit and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with the Resident Centered Care Plan addressing the unique factors contributing to wandering or elopement risk. Under Policy Explanation and Compliance Guidelines: 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 4. a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. d. Adequate supervision will be provided to help prevent accidents or elopements. 5. c. If the resident is not located in the building or on the grounds, Administrator or designee will notify the police department and serve as the designated liaison between facility and the police department. g. Appropriate reporting requirements to the State Survey agency should be conducted. Review of the History and Physical received by the facility before R1's admission and dated 9/18/2025 documented R1 had an altered mental status. R1 was provided with a seater (someone to watch the patient) at the hospital when he attempted to leave the hospital without medical advice and proper discharge. Review of R1's face sheet showed R1 was admitted with diagnoses of but not limited to cerebral infarction, end stage renal disease, cognitive communication deficit, unspecified dementia, and psychotic mood disturbance. Review of R1's admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated R1 had severe cognitive impairment. Review of R1's Comprehensive Care Plan (CCP) Initiated on 10/1/2025 documented R1 was at risk for wandering looking for his home. R1 was disoriented to place, had impaired safety awareness and wandered aimlessly. Care plan directed staff to distract R1 from wandering by offering pleasant diversions, structured activities, food, conversation, television and books. Review of R1's progress notes dated 10/1/2025 at 10:14 pm, Licensed Practical Nurse (LPN) CC documented on 10/1/2025 at approximately 5:30 pm to 6:00 pm. She observed R1 standing at North nurses' station, R1 requested to leave and stated, Am I able to go? I'm ready to go. LPN CC asked R1 to reveal his name and R1 mentioned his correct name. LPN CC informed R1 he could not leave and instructed him to return to his room. R1 acknowledged and turned around and walked back to his room. Review of a written statement signed and dated 10/2/2025, LPN DD documented at approximately 7:00 pm, the alarm sounded, she discovered the sound was coming from the North Hall close to the activity office. When she arrived at the door, she silenced the alarm. LPN DD documented she did not realize a Resident could have triggered the alarm. LPN DD further documented she was unaware R1 exited the facility until she returned to work to start her shift on 10/2/2025, DD worked the 7:00 am to 7:00 pm shift. LPN DD documented and concluded she had since been made aware of facility expectations, when an alarm had sounded and she was required to search the inside and outside of the facility and notify the police and the Administrator immediately. Review of R1's progress notes dated 10/2/2025 at 6:00 pm, LPN CC documented the following timeline in R1's progress notes: On 10/1/2025 at 7:00 pm - R1 LPN CC observed R1 standing outside his room, wearing personal clothing. At 8:00 pm - Certified Nurse Assistant (CNA) on North Hall reported R1 was missing. CNA stated she attempted to obtain weight from R1 but was unable to locate him. At 8:05 pm - R1's room checked and R1 was not in bed. At 8:15 pm - South Nurse's station notified to verify if R1 was on their unit. Staff reported they were unable to locate R1. Staff were informed of a potentially missing Resident. Code [NAME] (missing resident code) was announced, and all caregivers looked for R1. At 8:45 pm - Administration notified via</p>		